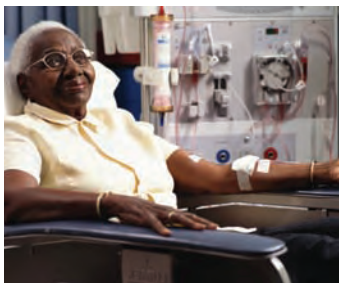

Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Outpatient Maintenance Dialysis–End-Stage Renal Disease
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare payment to **End-Stage Renal Disease (ESRD)** facilities for outpatient maintenance dialysis services furnished to Medicare beneficiaries with ESRD is based on a prospective payment system (PPS) known as the basic case-mix adjusted composite payment system. The base composite rate covers the costs of the dialysis treatment and certain routine drugs, laboratory tests, and supplies furnished at the patient's home or in a facility. Other items and services, particularly injectable drugs (e.g., erythropoietin [EPO], iron sucrose, vitamin D) and non-routine laboratory tests, are not included in the composite rate and are billed separately to Medicare. Separately billable services represent about 40 percent of total Medicare payments per dialysis treatment. The base composite rate is adjusted by a drug add-on payment to account for changes in the drug pricing methodology that occurred in 2005 and by case-mix factors (i.e., age, body size, and a special adjustment for pediatric patients).

Section 153(b) of the Medicare Improvements for Patients and Providers Act of 2008 replaces the current basic case-mix adjusted composite payment system with a bundled ESRD PPS for Medicare outpatient ESRD facilities beginning January 1, 2011. There will be a four-year transition period, with full implementation beginning January 1, 2014. ESRD facilities may make a one-time election to be excluded from the transition and accept payment entirely based on the payment amount under the ESRD PPS. During the transition, ESRD facilities will be paid a blend of the ESRD PPS and the current payment system, which is described in detail below.

BASIC CASE-MIX ADJUSTED COMPOSITE PAYMENT RATE SYSTEM



The basic case-mix adjusted composite payment rate system is a comprehensive PPS that covers a bundle of dialysis-related items and services routinely required for dialysis treatments to be furnished to Medicare beneficiaries in Medicare-certified ESRD facilities or in their homes (e.g., supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, and support services). Payment for all modalities of in-facility dialysis and Method I home dialysis are paid under the basic case-mix adjusted composite payment rate system. Payment for Method II home dialysis is not paid under the basic case-mix adjusted composite payment system and is described in detail below.

The following components are *not* included under the basic case-mix adjusted composite payment system:

- Method II home patients;
- Physician's professional services;
- Separately billable laboratory services;
- Separately billable drugs;
- Blood and blood products; and
- Bad debt.

A beneficiary may either receive maintenance dialysis at a Medicare-certified dialysis facility or at home. Each Medicare home dialysis beneficiary must choose the method by which Medicare pays for his or her dialysis services.

Under Method I, the dialysis facility with which the patient is associated must assume responsibility for providing all home dialysis

equipment and supplies and home support services. For these services, the facility receives the same payment rate as it would receive for an in-facility patient under the basic case-mix adjusted composite payment system. Under this arrangement, the ESRD facility bills the Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC), and the beneficiary is responsible for paying the ESRD facility any unmet Part B deductible amount and the 20 percent coinsurance requirement.

Under Method II, the beneficiary deals directly with a single Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier to secure the necessary supplies and equipment to dialyze at home. The selected supplier (not a dialysis facility) must take assignment and bill the Durable Medical Equipment Medicare Administrative Contractor. The beneficiary is responsible for paying his or her supplier for any unmet Part B deductible amount and the 20 percent Medicare Part B coinsurance requirement.

Composite Rate Covered Items and Services

In general, all items and services necessary for delivering outpatient maintenance dialysis are included in the composite rate including routinely provided drugs, laboratory tests, and supplies for dialysis-related services. Services must be furnished by the facility either directly or under arrangement.

Composite Rate Payment Methodology Including Adjustment Factors

The composite rate:

- Is applied on a per-treatment basis, with payments capped at an amount equal to three dialysis sessions per week;
- Is applicable to both facility and Method I home dialysis Medicare beneficiaries;
- Includes a budget neutral basic case-mix adjustment. Case mix adjusters include:
  - Age (<18, 18-44, 45-59, 60-69, 70-79, ≥ 80 years);
  - Body surface area; and
  - Body mass index;
- Includes wage indices based on acute hospital and employment data;
- Includes a budget neutral wage index adjustment; and
- Includes a drug add-on adjustment, which accounts for the difference between payments for separately billable drugs and payments based on a revised drug pricing methodology and eliminates the difference between composite payment system costs and payments.

The base composite payment rate for 2010 is $135.15 for both hospital-based facilities and independent facilities.

Effective January 1, 2010, the wage index adjustment is based on 100 percent of the Core-Based Statistical Area geographic definitions for purposes of determining urban and rural locales and the wage index floor is set at .65.

Effective January 1, 2010, the drug add-on adjustment to the composite rate is 15.0 percent.

SEPARATELY BILLABLE ITEMS AND SERVICES

In addition to the composite rate, dialysis facilities may receive additional payment for separately billable laboratory tests and drugs.

Separately Billable Laboratory Tests

Separately billable laboratory tests are paid according to the Clinical Diagnostic Laboratory Fee Schedule. Laboratory tests that are usually performed for dialysis patients are routinely covered at the frequency specified in the absence of indications to the contrary (i.e., no documentation of medical necessity is required other than knowledge of the patient's status as an ESRD beneficiary). When any of these tests is performed at the frequency greater than that specified, the additional tests are separately billable and are covered only if they are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the tests must be present on the claim using International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes.

Medicare beneficiaries do not pay a copayment for separately billable laboratory tests.

Separately Billable Drugs

Some drugs administered in the facility by facility staff are not covered under the composite rate but may be medically necessary for some beneficiaries who receive dialysis. These drugs must be billed separately and accompanied by medical justification either through information on the claim form or as requested by the FI/MAC. Staff time used to administer the drugs is covered under the composite rate. Supplies used to administer the drugs may be billed in addition to the composite rate.

Hospital-based facilities and independent ESRD facilities are paid the Average Sales Price of drugs plus six percent for separately billable drugs.

Medicare beneficiaries pay a 20 percent copayment for separately billable drugs.

Additional information about ESRD can be found at **http://www.cms.hhs.gov/ESRDpayment**, **http://www.cms.hhs.gov/ESRDGeneralInformation** and **http://www.cms.hhs.gov/center/esrd.asp** on the Centers for Medicare & Medicaid Services (CMS) website. On February 20, 2008, the ***Report to Congress: A Design for a Bundled End Stage Renal Disease Prospective Payment System*** was released as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and can be accessed at **http://www.cms.hhs.gov/ESRDGeneralInformation/Downloads/ESRDReportToCongress.pdf** on the CMS website.

On September 15, 2009, the ESRD PPS proposed rule went on display in the ***Federal Register*** and can be accessed at: **http://www.cms.hhs.gov/ESRPDPayment/PAY/list.asp** on the CMS website.

January 2010 ICN: 006469